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7 **UNITED STATES DISTRICT COURT**
8 **WESTERN DISTRICT OF WASHINGTON**

9 STATE OF WASHINGTON,

10 CIVIL ACTION NO.

11 Plaintiff,

12 COMPLAINT FOR DECLARATORY
13 AND INJUNCTIVE RELIEF

14 v.

15 DONALD TRUMP, in his official capacity
16 as President of the United States of
17 America; DON WRIGHT, in his official
18 capacity as Acting Secretary of the United
19 States Department of Health and Human
20 Services; U.S. DEPARTMENT OF
21 HEALTH AND HUMAN SERVICES;
22 STEVEN T. MNUCHIN, in his official
23 capacity as Secretary of the Department of
24 Treasury; U.S. DEPARTMENT OF
25 TREASURY; R. ALEXANDER ACOSTA,
26 in his official capacity as United States
Secretary of Labor; and UNITED STATES
DEPARTMENT OF LABOR,

Defendants.

22 **I. INTRODUCTION**

23 1. This suit challenges new rules issued by the Trump Administration that illegally
24 jeopardize women's health and economic success in order to promote certain religious and moral
25 views. To make matters worse, the Administration implemented its new rules without regard to

1 required legal procedures. The State of Washington brings this suit to protect the state and its
 2 women residents from the substantial harm the Administration's new rules inflict.

3 2. The Affordable Care Act requires most health plans and insurance providers to
 4 cover certain preventive health services at no added cost to American men and women. The
 5 initial version of the Act did not adequately cover medically necessary preventive care for
 6 women, such as contraceptive services and screening for gestational diabetes. But the Senate
 7 introduced the Women's Health Amendment, and as finally enacted in 2010 the Affordable Care
 8 Act required health plans and insurance providers to include women's preventive services at no
 9 out-of-pocket cost to women.

10 3. Contraceptive use among women is widespread, with over 99% of sexually active
 11 women using at least one method during their lifetime. Consequently, the Women's Health
 12 Amendment has been a dramatic success. By 2013, most women had no out-of-pocket costs for
 13 their contraception. One study estimated that roughly \$1.4 billion dollars per year in
 14 out-of-pocket savings on the pill resulted from the Affordable Care Act's contraceptive mandate.

15 4. The economic implications for women also are dramatic. Research links
 16 women's access to contraception to increases in the pursuit of college and advanced professional
 17 degrees, and to career trajectories with higher pay and prestige. Access to reliable contraception
 18 has contributed to women's increased earning power and the narrowing of the gender gap in pay.

19 5. On October 6, 2017, the Trump Administration issued two new regulations that
 20 slashed the contraceptive coverage introduced by the Affordable Care Act. One new set of rules
 21 allows any employer, not just a church or religious order, that asserts a religious objection to
 22 contraception to exempt itself from the requirement and carve out contraception coverage from
 23

1 its workplace insurance plan. The second set of rules authorizes certain employers with moral
2 but not religious objections to contraception to opt out of Congress's requirement. Further, the
3 new regulations change the prior rules and now allow objecting employers to dictate whether
4 their women employees can get contraception directly from the insurance provider, at no cost to
5 the employer.

6 6. The Administrative Procedure Act requires the federal government to provide
7 public notice and opportunity for comment before changing substantive rights and obligations
8 springing from the Affordable Care Act. Disregarding this obligation, the Trump Administration
9 has made the new rules effective immediately without notice and comment rulemaking. Even if
10 the Administration had complied with required procedures, its action would be illegal. The new
11 regulations violate the Equal Protection guarantee and the Establishment Clause in the United
12 States Constitution, the requirements of the Affordable Care Act, and the non-discrimination
13 provisions of the Affordable Care Act, the Civil Rights Act, and the Pregnancy Disability Act.
14 Finally, because the new regulations are arbitrary and capricious and ignore abundant evidence
15 of the importance of contraceptive coverage to women's health and economic opportunity, they
16 violate the substantive requirements of the Administrative Procedure Act.

17 7. The new regulations apply to nonprofit and for-profit employers, as well as to
18 private colleges or universities with religious or moral objections to contraception. As a result
19 of the new regulations, choices about contraception coverage will be made by employers and
20 private colleges and universities that issue student plans. For many women, their employers or
21 universities will determine whether they have no-cost coverage for the full range of
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1 FDA-approved contraceptive methods. Their choice of contraception will once again be limited
 2 by their own financial means.

3 8. More than 2.4 million women in Washington are of child-bearing age. Up to
 4 1.5 million women in Washington State face losing contraception coverage as a result of the
 5 Administration's new regulations. Washington maintains state government-funded programs to
 6 ensure Washington women have access to contraception and the economic opportunities it
 7 creates. Washington residents denied no-cost contraceptive coverage as a result of the new rules
 8 will be forced to turn to these programs to obtain contraceptive care. To prevent this injury to
 9 Washingtonians and the state's finances, Washington brings this suit to declare illegal and enjoin
 10 the new regulations.

12 **II. JURISDICTION AND VENUE**

13 9. The Court has jurisdiction pursuant to 28 U.S.C. §§ 1331, 2201(a) and 2202. The
 14 United States' sovereign immunity is waived by 5 U.S.C. § 702.

15 10. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b)(2) and (e)(1) and
 16 5 U.S.C. § 703. Defendants are the President and three U.S. departments and their respective
 17 department heads. The State of Washington is a resident of this judicial district and no real
 18 property is involved in this action.

20 **III. PARTIES**

21 **PLAINTIFF STATE OF WASHINGTON**

22 11. The Plaintiff is the State of Washington. The Attorney General is the chief legal
 23 adviser to the State of Washington. The Attorney General's powers and duties include acting in
 24 federal court on matters of public concern.

1 12. The State brings this action to redress harms to its proprietary interests, its
 2 quasi-sovereign authority, and its interests as *parens patriae*.

3 13. The State has declared its interest in protecting its female residents' "fundamental
 4 right to choose or refuse birth control" through statute. Wash. Rev. Code § 9.02.100.

5 14. The State has a quasi-sovereign interest in protecting the health and well-being
 6 of its residents. This interest extends to ensuring that its residents have access to a full
 7 complement of affordable reproductive health care services, including contraception, and can
 8 make personal, private decisions about their reproductive health and family planning.

9 15. The State also has an interest in avoiding greater costs to provide subsidized
 10 contraception and costs relating to unintended pregnancies.

11 16. The State and its residents will suffer significant and irreparable harm if women's
 12 access to affordable contraception through employer-based health insurance is diminished.

15 DEFENDANTS

16 17. Defendant Donald Trump is the President of the United States, and issued
 17 Executive Order 13798, "Promoting Free Speech and Religious Liberty" (May 4, 2017),¹ which
 18 directed Defendants to issue the rules challenged in this lawsuit. He is sued in his official
 19 capacity.

20 18. Defendant U.S. Department of Health and Human Services (HHS) is a federal
 21 cabinet department responsible for implementing and enforcing material portions of the
 22 Affordable Care Act. HHS is a Department of the Executive Branch of the U.S. Government,

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 26 ¹ <https://www.gpo.gov/fdsys/pkg/FR-2017-05-09/pdf/2017-09574.pdf>

1 and is an agency within the meaning of 5 U.S.C. § 551(1). HHS is one of the agencies that issued
2 the rules challenged in this lawsuit.

3 19. Defendant Don Wright is Acting Secretary of HHS. He is sued in his official
4 capacity.

5 20. Defendant U.S. Department of Labor (DOL) is a federal cabinet department
6 responsible for implementing and enforcing material portions of the Affordable Care Act. DOL
7 is a Department of the Executive Branch of the U.S. Government, and is an agency within the
8 meaning of 5 U.S.C. § 551(1). DOL is one of the agencies that issued the rules challenged in this
9 lawsuit.

10 21. Defendant R. Alexander Acosta is Secretary of DOL. He is sued in his official
11 capacity.

12 22. Defendant U.S. Department of Treasury (Treasury) is a federal cabinet
13 department responsible for implementing and enforcing material portions of the Affordable Care
14 Act. Treasury is a Department of the Executive Branch of the U.S. Government, and is an agency
15 within the meaning of 5 U.S.C. § 551(1). Treasury is one of the agencies that issued the rules
16 challenged in this lawsuit.

17 23. Defendant Steven T. Mnuchin is Secretary of Treasury. He is sued in his official
18 capacity.

IV. ALLEGATIONS

A. Statutory and Regulatory Background

1. The Affordable Care Act and the Contraceptive Coverage Requirement

24. In 2010, Congress enacted the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively the ACA). The ACA aims to increase the number of Americans covered by health insurance and decrease the cost of health care. *National Federation of Independent Business v. Sebelius*, 567 U.S. 519, 538 (2012).

25. The ACA, in its initial form, required non-grandfathered² group health plans and insurance providers to cover three categories of preventive health services at no added cost to the plan participant or beneficiary: “(1) evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.” 42 U.S.C. § 300gg-13(a)(1)-(3). Prevention is a well-recognized, effective tool in improving health and well-being and has been shown to be cost-effective in addressing many conditions early.³

² Grandfathered health plan coverage is that which has existed continually prior to March 23, 2010 and has not undergone any of several specified changes since that time. 29 C.F.R. § 2590.715-1251 (2010). The percentage of workers covered by grandfathered plans has decreased over time. <http://www.kff.org/report-section/ehbs-2017-section-13-grandfathered-health-plans/>.

³ Institute of Medicine, Clinical Preventive Services for Women: Closing the Gaps 16 (2011).

1 26. Recognizing that the initial draft left out preventive services that “many women’s
 2 health advocates and medical professionals believe are critically important,” Senator Barbara
 3 Mikulski introduced the Women’s Health Amendment, which added to the ACA’s minimum
 4 coverage requirements a new category of preventive services specific to women’s health.
 5 155 Cong. Rec. 28841 (2009). The amendment’s proponents noted that women pay significantly
 6 more than men for preventive care, and that such cost barriers operated to block many women
 7 from obtaining needed care at all. *See, e.g.*, 155 Cong. Rec. 29070 (statement of Sen. Feinstein)
 8 (“Women of childbearing age spend 68 percent more in out-of-pocket health care costs than
 9 men.”); *id.* at 29302 (statement of Sen. Mikulski) (“copayments are [often] so high that [women]
 10 avoid getting [preventive and screening services] in the first place”). The sponsors noted that
 11 increasing access to contraceptive services would yield important public health gains. *See, e.g.*,
 12 155 Cong. Rec. 29768 (statement of Sen. Durbin) (“This bill will expand health insurance
 13 coverage to the vast majority of the [17 million women of reproductive age in the United States
 14 who are uninsured] This expanded access will reduce unintended pregnancies.”).

17 27. As altered by the passage of the Women’s Health Amendment, the ACA requires
 18 new insurance plans to include coverage without cost sharing of “with respect to women, such
 19 additional preventive care and screenings not [otherwise required] as provided for in
 20 comprehensive guidelines supported by the Health Resources and Services Administration for
 21 purposes of this paragraph.” 42 U.S.C. § 300gg-13(a)(4). Congress included this provision
 22 because “women have different health needs than men, and these needs often generate additional
 23 costs.” 155 Cong. Rec. 29,070 (2009) (statement of Sen. Feinstein).

1 28. The Health Resources and Services Administration (HRSA) is a part of HHS.
 2 HRSA developed guidelines required under 42 U.S.C. § 300gg-13(a)(4) after consultation with
 3 the Institute of Medicine (IOM). The IOM is an arm of the National Academy of Sciences, an
 4 organization established by Congress “for the explicit purpose of furnishing advice to the
 5 Government.” *Public Citizen v. Dep’t of Justice*, 491 U.S. 440, 460, n.11 (1989).

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 7 29. The IOM convened a group of independent experts, including “specialists in
 8 disease prevention [and] women’s health,” which prepared a report evaluating the efficacy of a
 9 number of preventive services. *See* Institute of Medicine, Clinical Preventive Services for
 10 Women: Closing the Gaps 10 (2011) (IOM Report). The IOM defined preventive services as
 11 measures “shown to improve well-being, and/or decrease the likelihood or delay the onset of a
 12 targeted disease or condition.” *Id.* at 3.

13
 14 30. Based on the IOM’s review of the evidence, it recommended a number of
 15 preventive services for women, such as screening for gestational diabetes for pregnant women,
 16 screening and counseling for domestic violence, and at least one well-woman preventive care
 17 visit a year. IOM Report at 8-12. Consistent with the findings of “[n]umerous health professional
 18 associations” and other organizations, the IOM experts also determined that preventive coverage
 19 for women should include the “full range” of FDA-approved contraceptive methods. IOM
 20 Report at 10, 102-110. FDA-approved contraceptive methods include oral contraceptive pills,
 21 rings, patches, diaphragms and cervical caps, injections, implants, emergency contraceptive
 22 drugs, intrauterine devices (IUDs), and sterilization.

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 24 31. The IOM Report noted the disproportionate burden women carried for
 25 comprehensive health services and the adverse health consequences of excluding contraception

1 from preventive care available to employees without cost sharing. IOM Report at 19 (“[W]omen
 2 are consistently more likely than men to report a wide range of cost-related barriers to
 3 receiving . . . medical tests and treatments and to filling prescriptions for themselves and their
 4 families.”), 103-1-4, 107 (pregnancy may be contraindicated for women with certain medical
 5 conditions, for example, some congenital heart diseases, pulmonary hypertension, and Marfan
 6 syndrome, and contraceptives may be used to reduce the risk of endometrial cancer, among other
 7 serious medical conditions), 103 (women with unintended pregnancies are more likely to
 8 experience depression and anxiety, and their children face “increased odds of preterm birth and
 9 low birth weight”). The IOM also noted that nearly half of all pregnancies in the United States
 10 are unintended, and that unintended pregnancies can have adverse health consequences for both
 11 mothers and children. IOM Report at 102-103. In addition, the IOM observed, use of
 12 contraceptives leads to longer intervals between pregnancies, which “is important because of the
 13 increased risk of adverse pregnancy outcomes for pregnancies that are too closely spaced.” *Id.*
 14 at 103.

17 32. Consistent with the IOM’s suggestions, HRSA adopted guidelines
 18 recommending access to “[a]ll [FDA]-approved contraceptive methods, sterilization procedures,
 19 and patient education and counseling for all women with reproductive capacity” as prescribed
 20 by a health care provider. HRSA, HHS, Women’s Preventive Services Guidelines
 21 (August 2011), *available at* <https://www.hrsa.gov/womens-guidelines/index.html> (last visited
 22 September 29, 2017).

24 33. HHS, DOL, and the Treasury promulgated regulations requiring
 25 non-grandfathered group health plans to include coverage for, among other preventive services,
 26

1 the contraceptive services recommended in the HRSA Guidelines. 45 C.F.R. § 147.130(a)(1)(iv)
 2 (2013) (HHS); 29 C.F.R. § 2590.715-2713(a)(1)(iv) (2013) (Labor); 26 C.F.R.
 3 § 54.9815-2713(a)(1)(iv)(2013) (Treasury).

4 34. To address advancements in science and gaps identified in existing guidelines,
 5 including a greater emphasis on practice-based clinical considerations, HRSA awarded a
 6 five-year cooperative agreement in March 2016 to convene a coalition of clinician, academic,
 7 and consumer-focused health professional organizations and conduct a scientifically rigorous
 8 review to develop recommendations for updated Women’s Preventive Services Guidelines in
 9 accordance with the model created by the IOM (now known as the National Academy of
 10 Medicine (NAM)).⁴ The American College of Obstetricians and Gynecologists was awarded the
 11 cooperative agreement and formed an expert panel called the Women’s Preventive Services
 12 Initiative (WPSI). WPSI submitted its report “Recommendations for Preventive Services for
 13 Women” (hereinafter WPSI Report) to HHS in December 2016. WPSI Report at iii. As to
 14 contraception, WPSI recommended that adolescent and adult women have access to the “full
 15 range of female-controlled contraceptives to prevent unintended pregnancy and improve birth
 16 outcomes.” WPSI Report at 18.

19 35. HRSA updated its Women’s Preventive Services Guidelines on
 20 December 20, 2016, taking into account the clinical recommendations from WPSI.⁵ The
 21 Guidelines continue to recommend that “the full range of female-controlled” FDA-approved
 22 contraceptive methods, effective family planning practices, and sterilization procedures be
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25 ⁴ <https://www.hrsa.gov/womens-guidelines-2016/index.html>.

26 ⁵ <https://www.hrsa.gov/womens-guidelines/index.html>.

1 available as part of contraceptive care. [https://www.hrsa.gov/womens-guidelines-
2016/index.html](https://www.hrsa.gov/womens-guidelines-2016/index.html).

3 **2. Exemption for “Religious Employers”**

4 36. While the Women’s Health Amendment succeeded, a countermove which would
5 have enabled any employer or insurance provider to deny coverage based on its asserted
6 “religious beliefs or moral convictions,” the so-called “conscience amendment,” was voted down
7 by the Senate. 158 Cong. Rec. S539 (Feb. 9, 2012), S1162-S1173 (Mar. 1, 2012) (debate and
8 vote). That amendment, as observed by Senator Mikulski, would have “pu[t] the personal
9 opinion of employers and insurers over the practice of medicine.” *Id.* at S1127 (Feb. 29, 2012).

10 37. Instead, implementing regulations authorized a much narrower exemption for
11 religious employers (defined as “churches, their integrated auxiliaries, and conventions or
12 associations of churches,” and “the exclusively religious activities of any religious order” that
13 are organized and operate as nonprofit entities. 45 C.F.R. § 147.131(a); 26 U.S.C.
14 §§ 6033(a)(3)A(i), (iii)) from the requirement to cover contraceptive services under the
15 Guidelines. 45 C.F.R. § 147.131(a); 76 Fed. Reg. 46,621 (Aug. 3, 2011).

16 **3. Accommodation for “Eligible Organizations”**

17 38. Implementing regulations also provided an accommodation to certain “eligible
18 organizations”—nonprofit or closely held for-profit entities⁶ that object to providing coverage
19

20 23 6 The regulations originally only provided an accommodation to nonprofit organizations. 78 Fed. Reg. 39,870, 39,872, 39,874-39,886 (July 2, 2013). However, the Supreme Court held in *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014), that that the contraceptive coverage requirement substantially burdened the free exercise of a “closely-held” for-profit corporation’s religion, and that since the government had not demonstrated that the same accommodation provided to non-profits could not be made available to closely-held for-profits, the Religious Freedom Restoration Act prohibited the government from imposing the requirement on closely-held corporations. 134 S. Ct. at 2785. Accordingly, the regulations were revised to make the accommodation from the contraception mandate available to closely-held corporations. 80 FR 41,323-41,324.

1 for some or all of the contraceptive items or services required to be covered under the Act.
 2 45 C.F.R. § 147.131(b); 26 C.F.R. 54.9815-2713A(a). Such entities could opt out of providing
 3 contraceptive coverage by self-certifying to DOL or providing notice to the Secretary of HHS of
 4 their religious objections to coverage for all or a subset of contraceptive services. 45 C.F.R.
 5 § 147.131(b); 26 C.F.R. 54.9815-2713A(a).

6
 7 39. When a group health insurance issuer receives notice that one of its clients has
 8 invoked the accommodation provision, the issuer must then exclude contraceptive coverage from
 9 the employer's plan and provide separate payments for contraceptive services for plan
 10 participants without imposing any cost-sharing requirements on the eligible organization, its
 11 insurance plan, or its employee beneficiaries. 45 C.F.R. § 147.131(c). In the case of self-insured
 12 religious organizations entitled to the accommodation, the third-party administrator of the
 13 organization must "provide or arrange payments for contraceptive services" for the
 14 organization's employees without imposing any cost-sharing requirements on the eligible
 15 organization, its insurance plan, or its employee beneficiaries. 26 C.F.R. § 54.9815-2713A(b).
 16 Thus, women employed by "eligible organizations" were still entitled under the ACA to
 17 coverage for FDA-approved contraception at no additional cost to themselves.

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 19 **B. Executive Order 13798**

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 21 40. On May 4, 2017, President Trump signed Executive Order 13798, entitled
 22 "Promoting Free Speech and Religious Liberty." This Executive Order is attached to this
 23 Complaint as Exhibit D. The Executive Order directs the Secretaries of Treasury, DOL, and
 24 HHS to "consider issuing amended regulations, consistent with applicable law, to address
 25 conscience-based objections to the preventive-care mandate promulgated under section

1 300gg-13(a)(4) of title 42, United States Code.” Under the express terms of the Executive Order,
 2 any amended regulations were required to comply with the ACA, as well as with federal
 3 non-discrimination laws and the Constitution.

4 **C. 2017 Interim Final Rules and 2017 Updated Guidelines**

5 41. On October 6, 2017, relying in part on Executive Order 13798 as justification,
 6 HHS, DOL, and Treasury issued two sets of Interim Final Rules with respect to preventive care
 7 services for women required to be covered under the ACA (collectively referred to as the 2017
 8 Interim Final Rules).

9 42. Taken together, the 2017 Interim Final Rules greatly expand eligibility for a
 10 complete exemption to the ACA’s requirement that employers ensure women have access to
 11 insurance coverage for contraception without cost. The new regulations expand the *entities* to
 12 which the exemption is available. Rather than applying just to churches and religious orders, the
 13 exemption now applies to *all* for-profit or nonprofit employers that assert an objection to
 14 contraception based on their religious beliefs. Women employees of these employers now can
 15 be required to pay for their contraception or, if they cannot, go without.

16 43. The 2017 Interim Final Rules also expand the *reason* the exemption may be
 17 claimed. The new regulations create an exemption for all employers, except those that are
 18 publicly traded, that have *moral* objections to contraception. These employers too can deny their
 19 women employees insurance coverage for contraception.

20 44. Furthermore, the new regulations significantly cut back the previous
 21 accommodation that allowed women who worked for religiously affiliated non-profits or closely
 22 held for-profit corporations to obtain contraception at no out-of-pocket cost. Most significantly,

1 the accommodation is entirely voluntary to exempt employers; if an employer that qualifies for
 2 an exemption declines to seek the accommodation, it may ignore it. The new rules undercut the
 3 previous system whereby women employees of objecting employers nevertheless were entitled
 4 to obtain insurance coverage of contraception from the insurance carrier or third-party
 5 administrator, at no cost to their employer.
 6

7 45. Further, the expanded exemption also applies to private institutions of higher
 8 education that issue student health plans, where they object to contraception for religious or
 9 moral reasons. These institutions may single out contraception, among all of their male and
 10 female students' health care needs, for denial of coverage. For these institutions, providing an
 11 accommodation that permits their female students to maintain insurance coverage for their
 12 contraception at no cost to the institution is entirely voluntary.⁷
 13

14 46. The first set of 2017 Interim Final Rules issued by HHS, DOL, and Treasury,
 15 Document 2017-21851 (scheduled to be published in the Federal Register on October 13, 2017),
 16 is entitled "Religious Exemptions and Accommodations for Coverage of Certain Preventive
 17 Services Under the Affordable Care Act" (hereinafter Religious IFRs).⁸ As stated, the Religious
 18 IFRs make the religious exemption available to *any* objecting entity that claims to object to
 19 establishing, maintaining, providing, or arranging coverage, payments, or a plan that provides
 20 coverage or payments for some or all contraceptive services based on its sincerely held religious
 21 beliefs. Religious IFRs at 162 (45 C.F.R. § 147.132(a)(2)).
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⁷ State laws requiring fully-insured plans to provide access to contraceptive coverage have not been
 25 displaced by the new rules. *See infra* ¶ 69.

26 ⁸ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-21851.pdf>. The Religious IFRs
 are attached to this Complaint as Exhibit A.

1 47. The second set of 2017 Interim Final Rules, Document 2017-21852 (scheduled
 2 to be published in the Federal Register on October 13, 2017), is entitled “Moral Exemptions and
 3 Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act”
 4 (hereinafter Moral IFRs).⁹ The Moral IFRs create a moral exemption from the requirement to
 5 cover contraceptive services available to any non-profit entity, for-profit entity with no
 6 publicly-traded ownership interests, institution of higher education, or issuer that so objects
 7 based on its “sincerely held moral convictions.” Moral IFRs at 25, 99 (45 C.F.R.
 8 § 147.133(a)(2)).

10 48. On October 6, 2017, HRSA also updated its “Women’s Preventive Services
 11 Guidelines” (hereinafter 2017 Updated Guidelines) to provide that “[t]hese Guidelines do not
 12 provide for or support the requirement of coverage or payments for contraceptive services with
 13 respect to a group health plan established or maintained by an objecting organization, or health
 14 insurance coverage offered or arranged by an objecting organization” as set forth in the moral
 15 and religious IFRs set forth above. HRSA, Women’s Preventive Services Guidelines
 16 (October 2017), available at <https://www.hrsa.gov/womens-guidelines/index.html> (last visited
 17 October 6, 2017).¹⁰ The Guidelines’ support of the recommendation to provide coverage without
 18 cost sharing of “[a]ll Food and Drug Administration approved contraceptive methods,
 19 sterilization procedures, and patient education and counseling for all women with reproductive
 20 capacity” is otherwise unaffected. *Id.*

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 25 ⁹ <https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-21852.pdf>. The Moral IFRs are
 26 attached to this Complaint as Exhibit B.

27 ¹⁰ The 2017 Updated Guidelines are attached to this Complaint as Exhibit C.

1 49. The 2017 Interim Final Rules and 2017 Updated Guidelines vastly expand the
 2 exemption from the contraception coverage requirement previously available only to religious
 3 employers to include any “objecting organization,” which is defined to include any other kind
 4 of entity other than a government employer. Under the 2017 Interim Final Rules and
 5 2017 Updated Guidelines, any entity that “objects to establishing, maintaining, providing,
 6 offering, or arranging (as applicable) for coverage, payments, or a plan that provides coverage
 7 or payments for some or all contraceptive services” based on “religious beliefs,” or any similar
 8 nonprofit or for-profit entity with no publically traded ownership interests based on “moral
 9 convictions” is completely exempt from the contraceptive mandate.

10 50. The 2017 Interim Final Rules and 2017 Updated Guidelines make the
 11 accommodation process—which provided a mechanism to ensure women still had access to
 12 contraceptive coverage at no cost to the employer—entirely optional for all objecting entities
 13 entitled to exemption.

14 51. The 2017 Interim Final Rules provide that “exempt entities will not be required
 15 to comply with a self-certification process.” Religious IFRs at 61; *see also id.* at 162 (45 C.F.R.
 16 § 147.132(a)(2)). A company that wants to take advantage of the exemption need not certify that
 17 its owners have a religious or moral objection to contraception. It merely needs to drop or omit
 18 contraception coverage from its plan’s terms and comply with other applicable law.

19 52. The 2017 Interim Final Rules and 2017 Updated Guidelines are substantive
 20 changes that were issued prior to the passing of any notice and comment period. The
 21 Departments cited statutory general rulemaking authority as the basis for foregoing notice and
 22

1 comment. Generic grants of rulemaking authority do not permit the denial of public participation
 2 required by the APA.

3 53. The Departments are not subject to any court order or statutory deadline requiring
 4 them to place the Interim Final Rules into effect without consideration of public comments on
 5 the changes they wrought.
 6

7 **D. Injuries to the State and Its Residents**

8 54. Washington has standing to bring this action because Defendant's 2017 Interim
 9 Final Rules and Updated 2017 Guidelines will cause immediate and substantial harm to the
 10 State's quasi-sovereign, proprietary and *parens patriae* interests.

11 55. The State's quasi-sovereign interest in protecting the health and well-being of its
 12 residents includes ensuring that its residents have access to affordable contraception and can
 13 make personal, private decisions about their reproductive health and family planning unfettered
 14 by their employers. Indeed, the State's has declared its interest in protecting individuals'
 15 "fundamental right to choose or refuse birth control" through statute. Wash. Rev. Code
 16 § 9.02.100.

18 56. Eliminating the requirement for coverage of contraception services by
 19 employer-and higher education-sponsored health plans will also cause harm to Washington
 20 citizens, whom the State represents through its *parens patriae* authority.
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1 57. Implementation of the 2017 Interim Final Rules and 2017 Updated HRSA
 2 Guidelines will affect the health and financial well-being of numerous women and families who
 3 reside in Washington.¹¹

4 58. Pregnancy is a medical condition that poses risks to, and consequences for, a
 5 woman.

6 59. According to the American College of Obstetricians and Gynecologists, “[a]ccess
 7 to contraception is a medical necessity for women during approximately 30 years of their
 8 lives.”¹²

9 60. Virtually all (99%) sexually active women in the United States have used at least
 10 one contraceptive method at some point in their lifetime.

11 61. Contraception use reduces the occurrence of unintended pregnancy and abortion.

12 62. Contraceptive use also helps women and couples time and space their births,
 13 which helps to reduce the risk of poor birth outcomes, such as low birth weight, preterm birth,
 14 and small size for gestational age.

15 63. Without insurance coverage, contraception costs can exceed \$1,000 a year.

16 64. Early research has also associated the contraception coverage requirement with a
 17 historic drop in the U.S. abortion rate that occurred in 2014.

21
 22
 23 ¹¹ The available data focus on the impact of the provision or denial of contraception on women. However,
 24 the State recognizes that the denial of coverage for reproductive health care also affects people who do not identify
 25 as women, including some gender non-conforming people and some transgender men.

26 ¹² ACOG Statement on Supreme Court Remand of *Zubik v. Burwell* (May 16, 2016), available at
<https://www.acog.org/About-ACOG/News-Room/Statements/2016/ACOG-Statement-on-Supreme-Court-Remand-of-Zubik-v-Burwell> (last visited Oct. 9, 2017).

1 65. A recent nonpartisan poll found that a majority of women would struggle to afford
 2 birth control if they had a co-pay.¹³

3 66. Contraception coverage also impacts women's educations, careers, and economic
 4 standing. "The ability of women to participate equally in the economic and social life of the
 5 Nation has been facilitated by their ability to control their reproductive lives." *Planned*
 6 *Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 856 (1992). The availability of
 7 contraceptives has been associated with wage gains made by women since the advent of legal
 8 methods of birth control in the 1960s.

9 67. Some contraceptive methods also are used for noncontraceptive purposes, such
 10 as treatment for acne, menstrual pain, and endometriosis.

11 68. American women have saved approximately \$1.4 billion per year on birth control
 12 pills alone since the ACA began requiring coverage of contraception benefits. Prior to enactment
 13 of the ACA, contraception accounted for between 30% and 44% of women's out-of-pocket
 14 expenses for health care costs. When the ACA required coverage for contraception, women's
 15 out-of-pocket costs declined 38% for birth control pills and 68% for IUDs.

16 69. Washington has a Contraceptive Parity Rule that requires health plans that offer
 17 coverage of prescription drugs or devices to provide equal coverage for prescription
 18 contraceptives. WAC 284-43-5150. This Rule, however, does not apply to employer self-funded
 19 insurance plans, which are governed by ERISA.

20 21 22 23 24 25 26 ¹³ <https://www.scribd.com/document/342699692/PerryUndem-Gender-and-Birth-Control-Access-Report>.

1 70. Removing the requirement for employer-sponsored plans to cover contraception
 2 will increase overall health care costs for Washington residents and increase their risk of poorer
 3 health outcomes.

4 71. According to the most recent data from the U.S. Census Bureau, more than
 5 2.4 million women of child-bearing age reside in Washington. Bureau of Labor Statistics data
 6 reveals that the total civilian workforce in Washington in 2016 was 3,639,000. Of those,
 7 approximately 1.7 million workers were women and approximately 1.3 million were of
 8 child-bearing age.

9 72. Nationally, at least 61% of all covered employees are enrolled in employers'
 10 self-funded insurance plans.

11 73. The 2017 Interim Final Rules and 2017 Updated Guidelines will impact up to
 12 1.5 million insureds – plus their spouses and dependents – in Washington who receive insurance
 13 through their employers' self-funded plans. Considering only women of child-bearing age in the
 14 civilian workforce, and not spouses or daughters of other insureds, the new rules will impact up
 15 to 800,000 women in Washington.

16 74. In addition to the impact on Washington residents, the implementation of
 17 2017 Interim Final Rules and 2017 Updated Guidelines will increase the costs borne by the State
 18 as residents who lose coverage for contraception through their employer seek coverage through
 19 State-subsidized programs which provide subsidized contraceptive coverage, including
 20 Medicaid.

21 75. Washington subsidizes family planning services through the Department of
 22 Health's Family Planning Program (Family Planning Program), a Title X Family Planning

1 Program. *See* 42 U.S.C. § 300. This program provides for family planning, and it funds
 2 13 agencies with 71 clinic sites throughout Washington that offer affordable contraceptive
 3 services, including birth control and long-acting reversible contraception. In 2016, health care
 4 providers funded through the Family Planning Program served 90,168 clients in over 125,316
 5 clinic visits in Washington.
 6

7 76. Washington's Department of Health provides reproductive health services to
 8 individuals with incomes that are less than 251% of the Federal Poverty Level on a sliding fee
 9 scale. Washington State provides \$8.8 million of funding to the Family Planning Program per
 10 year. Some women who lose coverage for contraception from their employers will be forced to
 11 seek contraception from the Family Planning Program.
 12

13 77. The Washington Health Care Authority administers the Take Charge Program
 14 which provides family planning services, including the provision of contraception, to uninsured
 15 individuals with income below 260% of the Federal Poverty Level. The Take Charge Program
 16 is authorized through a Section 1115 waiver from the Centers for Medicare and Medicaid
 17 Services as a research and demonstration project. *See* 42 U.S.C. §1315. Take Charge is funded
 18 by state and federal dollars. Some women who lose coverage for contraception from their
 19 employers will be forced to seek contraception from the Take Charge Program.
 20

21 78. The reduction in employer-based coverage of contraception for women of
 22 reproductive capacity will result in more unintended pregnancies in Washington. Increased
 23 unintended pregnancies will cause Washington's Medicaid program to incur greater costs in
 24 covering prenatal care and delivery services for low-income women. Additionally, individuals
 25
 26

1 || who increase the size of their family may become Medicaid eligible and cause the Medicaid
2 || program to incur greater costs.

79. Washington's 2013 unintended pregnancy rate was 37%.

5 80. Washington's Medicaid program provides coverage for prenatal care and
6 delivery services for women at or below 193% of the Federal Poverty Level. *See Wash. Admin.*
7 Code § 182-505-0115.

8 81. In 2010, the cost of Medicaid-financed prenatal care and delivery in Washington
9 was \$220 million, or \$10,124 per birth. Fifty-one percent of these Medicaid-covered births
10 resulted from unintended pregnancies. Limiting access to contraceptives will likely increase the
11 number of unplanned births that are publicly funded in Washington, and the State's costs will
12 increase for each additional birth.

14 82. In 2016, pregnancy-related expenses in Washington, including payments by both
15 the Department of Health and Medicaid, were \$426,513,331.

V. CLAIMS FOR RELIEF

Count I

19 83. The State realleges and incorporates by reference the allegations set forth in each
20 of the preceding paragraphs of this Complaint.

84. The Due Process Clause of the Fifth Amendment to the United States
Constitution requires equal protection of the laws.

23 85. The ACA mandates that non-grandfathered insurance plans provide coverage for
24 preventive care for men and women. The 2017 Interim Final Rules and 2017 Updated Guidelines
25 carve out an exemption specific to women's reproductive health care. As a result of Defendants'
26

1 new regulations, generally only women, not men, may have coverage for reproductive health
 2 care denied based on their employer's religious or moral objection.

3 86. The 2017 Interim Final Rules and 2017 Updated Guidelines intentionally
 4 interfere with women's ability to access necessary preventive care which is necessary to their
 5 equal participation in education, the workforce, and other elements of economic opportunity in
 6 our country.

7 87. The 2017 Interim Final Rules and 2017 Updated Guidelines also perpetuate
 9 gender stereotypes.

10 88. The 2017 Interim Final Rules and corresponding exemption in the 2017 Updated
 11 Guidelines do not serve an important governmental objective sufficient to justify the
 12 gender-based discrimination.

13 89. By purporting to legally authorize employers, institutions of higher education,
 14 and other entities to deny only women the preventive health benefits that they need, the
 15 2017 Interim Final Rules and the 2017 Updated HRSA Guidelines classify based on gender and
 16 therefore violate the Due Process Clause of the Fifth Amendment to the United States
 17 Constitution.

18 90. Absent injunctive and declaratory relief with respect to the 2017 Interim Final
 19 Rules and 2017 Updated Guidelines, the State and its citizens will continue to be harmed by
 20 Defendants' illegal actions.

21
Count II
Violation of the First Amendment—Establishment Clause

22 91. The State realleges and incorporates by reference the allegations set forth in each
 23 of the preceding paragraphs of this Complaint.

92. The Establishment Clause of the First Amendment prohibits the federal government from preferring one religion over another, and requiring people to bear the burdens of religions to which they do not belong.

93. The Religious IFRs and the corresponding portion of the 2017 Updated Guidelines are intended to and have the effect of advancing, imposing, and endorsing certain religious interests. For example, they permit a for-profit business to impose the costs of its owners' anti-contraception beliefs on employees (and their dependents). Based on the religious beliefs of an employer or institution of higher education, the Religious IFRs deny women access to contraceptive coverage that the ACA would otherwise secure.

94. The Religious IFRs allow employers to decide whether employees receive separate contraceptive coverage through the accommodation process, at no cost to the employers. Employers have no legitimate interest in injecting their religious beliefs into this independent method for providing contraceptive coverage.

95. Through their actions, including those described above, Defendants have violated the Establishment Clause of the First Amendment.

96. Absent injunctive and declaratory relief with respect to the 2017 Interim Final Rules and 2017 Updated Guidelines, the State and its residents will continue to be harmed by Defendants' illegal actions.

Count III
Violation of the Administrative Procedure Act
Procedural Violations

1. The State realleges and incorporates by reference the allegations set forth in each of the preceding paragraphs.

1 2. The 2017 Interim Final Rules and 2017 Updated Guidelines have changed the
 2 substantive rights and obligations imposed by the Affordable Care Act and prior implementing
 3 regulations on employers, issuers, and others.

4 3. The 2017 Interim Final Rules and 2017 Updated Guidelines constitute final
 5 agency action and are legislative rules within the meaning of the Administrative Procedure Act

6 4. The 2017 Interim Final Rules and 2017 Updated Guidelines purport to take effect
 7 immediately, without the required 30-day waiting period between publication and effective date,
 8 without good cause for doing so.

10 5. The 2017 Interim Final Rules and 2017 Updated Guidelines were adopted
 11 without observing the notice and comment procedures required by the Administrative Procedure
 12 Act, which include publishing the proposed rule, allowing an appropriate time for “interested
 13 persons [to have] an opportunity to participate in the rule making through submission of written
 14 data, views, or arguments with or without opportunity for oral presentation.” 5 U.S.C. §§553(b),
 15 (c).

17 6. The Defendants did not have good cause to forgo notice and comment
 18 rulemaking.

19 7. Therefore, Defendants have taken agency action not in observance with
 20 procedures required by law, and the State is entitled to relief pursuant to 5 U.S.C. §§ 553 and
 21 706(2)(D).

23 8. Absent injunctive and declaratory relief with respect to the Interim Final Rules
 24 and 2017 Updated Guidelines, the State and its residents will continue to be harmed by
 25 Defendants’ illegal actions.

Count IV
Violation of the Administrative Procedure Act
Arbitrary and Capricious Action

9. The State realleges and incorporates by reference the allegations set forth in each of the preceding paragraphs.

10. The 2017 Interim Final Rules and 2017 Updated Guidelines reverse a prior agency decision without providing a reasoned explanation for this change in policy.

11. The 2017 Interim Final Rules and 2017 Updated Guidelines are not evidence-based or evidence-informed.

12. Defendants' explanation for their decision to exempt any entity with religious or moral objections runs counter to the evidence submitted during the comment period for these 2017 Interim Final Rules and the predecessor rules.

13. Thus, Defendants' issuance of the 2017 Interim Final Rules and 2017 Updated Guidelines was arbitrary and capricious within the meaning of 5 U.S.C. § 706(2)(A).

14. Absent injunctive and declaratory relief with respect to the 2017 Interim Final Rules and 2017 Updated Guidelines, the State and its residents will continue to be harmed by Defendants' illegal actions.

Count V

**Violation of the Administrative Procedure Act
Agency Action Not in Accordance With Law, Contrary to Constitutional Rights, and In
Excess of Statutory Jurisdiction**

**(First Amendment to the United States Constitution,
Fifth Amendment to the United States Constitution,
Civil Rights Act, Pregnancy Discrimination Act, and
Affordable Care Act)**

15. The State realleges and incorporates by reference the allegations set forth in each of the preceding paragraphs.

16. The APA requires that agency action that is “in excess of statutory jurisdiction, authority, or limitations, or short of statutory right,” “not in accordance with law” or “contrary to constitutional right” be held unlawful and set aside. 5 U.S.C. § 706(2).

17. The 2017 Interim Final Rules and 2017 Updated Guidelines, which allow employers to choose whether their employees will receive coverage for contraception, are not in accordance with and in excess of statutory authority set forth in the ACA, which require coverage for preventive services for women and do not provide an exception for religious or moral objections. 42 U.S.C. § 300gg-13(a)(4).

18. The expanded exemptions are not required by the Religious Freedom Restoration Act or any other provision of federal law.

19. The 2017 Interim Final Rules and 2017 Updated Guidelines are contrary to the constitutional protections afforded by the First and Fifth Amendments, as described above.

20. The 2017 Interim Final Rules and 2017 Updated Guidelines are not in accordance with the Civil Rights Act, as amended by the Pregnancy Disability Act, which prohibits discrimination based on sex or capacity to be pregnant. 42 U.S.C. 2000e *et seq.* (Title VII).

21. The 2017 Interim Final Rules and 2017 Updated Guidelines are not in accordance with provisions of the ACA that prohibits discrimination based on gender. 42 U.S.C. § 18116.

22. The 2017 Interim Final Rules and 2017 Updated Guidelines are not in accordance with provisions of the ACA that prohibit the promulgation of any regulation that “[c]reates any unreasonable barrier to the ability of individuals to obtain appropriate medical care,” “[i]mpedes timely access to health care services,” or “[l]imits the availability of health care treatment for the full duration of a patient’s medical needs.” 42 U.S.C. § 18114.

23. Absent injunctive and declaratory relief with respect to the 2017 Interim Final Rules and 2017 Updated Guidelines, the State and its residents will continue to be harmed by Defendants' illegal actions.

IX. PRAYER FOR RELIEF

Wherefore, the State of Washington prays that the Court:

a. Declare that the 2017 Interim Final Rules and 2017 Updated Guidelines' exemptions for religious and moral objections are unauthorized by and contrary to the Constitution and laws of the United States;

b. Declare that the 2017 Interim Final Rules and 2017 Updated Guidelines were not promulgated in conformance with the procedures required by the Administrative Procedure Act;

c. Declare that the 2017 Interim Final Rules and 2017 Updated Guidelines are arbitrary and capricious and short of statutory right;

d. Issue Preliminary and Permanent Injunctions enjoining Defendants from implementing or enforcing the 2017 Interim Final Rules and the 2017 Updated Guidelines' expanded exemptions for religious and moral objections;

- e. Award Washington its costs and reasonable attorney fees; and
- f. Award such additional relief as the interests of justice may require.

DATED this 9th day of October, 2017.

Respectfully submitted,

/s/ Jeffrey T. Sprung

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